Children and Youth Services Review 88 (2018) 486–489

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Parents' perceptions of the value of sexual abuse medical evaluations of their children

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ABSTRACT

Most sexual abuse medical examinations reveal no abnormalities. This study's objective was to assess the value of a "certification of normalcy" for parents whose children had/didn't have abuse evaluations. Two questionnaires were developed for administration to guardians of sexually abused children enrolling in a specialized outpatient mental health program. On the questionnaire given to 42 parents whose children had received medical evaluations, caregivers commonly endorsed prior concerns about injuries, infections, genital penetration, and proof of sexual assault. 74% rated the examinations as helpful to them and 41% of caregivers believed knowledge of the results was helpful for their children age seven or older. 76% of guardians indicated they would obtain examinations if events were recreated. The questionnaire given to 47 parents of non-examined children revealed less concern about injury, infection and signs of penetration. However, 28% of these caregivers indicated they would obtain examinations if events were recreated. Study results support a belief that sexual abuse medical evaluations have value to many parents.

1. Introduction

The medical evaluations of children and adolescents who have been sexually abused have been accorded four purposes: screening for injuries and infection, identification of physical evidence of the sexual abuse, initiation of medical treatment, and reassurance of victims and parents based upon the examination findings (Britton, 1998; Finkel, 2005; Walsh et al., 2007). Most sexual abuse examinations reveal an absence of physical evidence of the abuse (Adams et al., 1994). Examiners usually can provide reassurance of wellness to the children and parents, a "certification of physical normality" (Finkel, 2005; Jones & Farst, 2011).

Parental and child anxiety about the sexual abuse medical exam may lead parents and professionals to avoid referring children for this service. While children and parents may indeed experience some anxiety regarding the sexual abuse exam, most do not express clinically significant anxiety (Gully et al., 2000; Rheingold et al., 2013). Children with more severe abuse, cognitive difficulties, a chronic medical and/or prior mental health diagnosis, who have an ano-genital exam requiring anal or genital cultures, and who lack private/public medical insurance may benefit from more exam preparation (Gully et al., 2000; Horner et al., 2009). The results of these studies suggest the importance of providing a quality exam with careful preparation of parents and children in reducing their worry and anxiety. In one study, parents found the medical examination significantly less stressful than they had anticipated. The authors concluded that medical exams for child sexual abuse do not further traumatize the child and are in fact reassuring to children and parents (Marks et al., 2009).

Nevertheless, the specific value of sexual abuse medical evaluations to those parents whose children had them appears to be largely unreported, and the literature has been silent on possible parental health and physical injury concerns. Similarly, parents' perceptions of the value of sexual abuse medical examinations to their children are also unreported. What is known, however, is that psychological outcomes for sexual abuse victims are significantly affected by a family's response to the abuse (Deblinger et al., 1999). The purpose of this study is to assess parents' perceptions of the value of sexual abuse medical evaluations when entering a sexual abuse mental health family treatment program. The study began by giving a survey to patients to determine if families needed referrals for medical examinations and evolved into a

Abbreviations: UAMS, University of Arkansas for Medical Sciences; ACH, Arkansas Children's Hospital; REDCap, Research Electronic Data Capture

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https://doi.org/10.1016/j.childyouth.2018.04.005
Received 22 November 2017; Received in revised form 30 March 2018; Accepted 2 April 2018
Available online 04 April 2018
0190-7409/

small naturalistic pilot study to assess the value of sexual abuse medical examinations to parents.

2. Materials and methods

2.1. Setting

Children believed to have been sexually abused or assaulted (hereafter called sexually abused) were referred for mental health treatment to the Family Treatment Program of the Center for Children at Risk of the University of Arkansas for Medical Sciences (UAMS) and Arkansas Children's Hospital (ACH). The Center provides a multi-disciplinary program for medical, social, and mental health evaluations and treatment of sexually abused children, adolescents, and their parents/guardians. They are referred to the Center by law enforcement agencies, child protective services, the ACH Emergency Department, primary care physicians, and courts. Provision of the medical examinations is based on the nature of the abuse, the information received from the referral sources, and the request for an appointment. Most of the children in this study who had prior sexual abuse examinations received them in the medical facility of the Center or the ACH Emergency Department. A few were examined elsewhere on the ACH campus or in the offices of primary care physicians. The psychological and educational support given to the children and parents varied when the examinations were not performed in the Center.

2.2. Study design and participants

The authors compiled questions to assess parental issues related to sexual abuse medical evaluations, and the results were assembled into two questionnaires. A questionnaire for parents whose children had received medical evaluations contained items related to parental concerns about their children before the medical evaluation, the helpfulness of knowing the results of the evaluation, the effects of the exams on the parents' worry about their children's health, and possible harmful effects of the evaluations on the children. The other questionnaire, for parents whose children had not received sexual abuse medical evaluations, contained questions related to concerns about possible injuries, infections, physical evidence of penetration/proof of the sexual abuse, and whether a sexual abuse exam had been recommended. All parents were asked if they would get an evaluation if circumstances repeated themselves and whether they had life experiences that made/would make a medical evaluation of their child(ren) difficult for them. The complete questionnaires are available in Appendix A. The questionnaires have not been used for any other purpose outside the given study and hence there is no available validity or reliability information concerning these measures. They were formatted and designed for response scanning by Remark OMR software (version 6) and were eventually entered into a Research Electronic Data Capture (REDCap) database (Harris et al., 2009).

Parents/Guardians were asked upon enrollment in the Family Treatment Program to complete the questionnaires anonymously. They were told the purpose was to enhance the treatment of children and families. Only biological parents and legal guardians were included in the analysis due to the requirement of their consent for evaluation and treatment of their children in the clinic. Since the project was initiated for quality assurance/improvement purposes, the UAMS Institutional Review Board deemed the administration of the questionnaires was for the purpose of evaluation of an implemented clinical program rather than for research. As such, the work described in this study has been carried out in accordance with The Code of Ethics of the World Medical Association (Declaration of Helsinki). Parental consents for enrollment in the study were not obtained and parents did not receive a stipend. Completion of the questionnaires was not required for provision of appropriate evaluation and treatment services.

2.3. Statistical methods

All survey responses were categorical in nature and were summarized as frequency and percentages. Missing responses were imputed as negative responses for binary responses (i.e. No/Yes), or Unknown/Missing for multiple category responses. Bivariate statistical tests were performed using Chi-square test of independence; Fisher's exact test was used when Chi-square assumptions failed to be met. Logistic regression was also used to associate survey responses with predictor variables to explore the multi-dimensional nature of the response profile. All analyses were completed using Stata/MP v13.1 (College Station, TX).

3. Results

3.1. Study population

Questionnaires were completed for 103 children, but 14 were excluded because the questionnaires were not completed by parents or guardians. Of the remaining 89 children whose parents completed the questionnaires, 42 (47%) received medical evaluations for sexual abuse prior to enrollment and 47 (53%) did not. Only 9% (4/47) of parents of children who did not receive sexual abuse examinations reported that an exam had been suggested. Overall, 18 (20%) of children seen were ≥ 13 years, 50 (56%) were 7 to < 13 years, 16 (18%) were 4 to < 7 years, and 5 (6%) were < 4 years. Females comprised 59 (66%) of the children and 86 (97%) of the parents.

The offenders were relatives of 28 (67%) of the children who had medical examinations and 36 (77%) of those who had not received examinations ($P = .30$). The parents were present for the examinations of 38 (90%) of the 42 children who had received examinations. Medical examinations of 22 (52%) were performed in the ACH Emergency Department, 13 (31%) in the Center, and the remaining seven (17%) in other sites on and off the ACH campus.

3.2. Concerns about the physical health of the children

Concerns about signs of abuse were reported by 32 parents (76%) of examined children, and18 (43%) had been concerned that the examinations might reveal evidence of injuries. Twenty-two (52%) of the parents reported having been concerned about physical signs of penetration before their children's examinations, and the same number had been concerned about physical evidence to legally prove sexual abuse. Parents who had been present at the time of the examination were similarly concerned about signs of penetration and physical evidence (21/38 or 55%). Sixteen (38%) of parents whose children received medical exams had been concerned about infections, but only 8/28 (29%) were concerned if the offender was a relative.

Only five (11%) of the parents of non-examined children had been concerned about signs of abuse ($P < .001$) and only two (4%) recorded concerns about physical injury. They reported fewer concerns regarding physical signs of penetration (two [4%], $P < .001$) and physical evidence to legally prove sexual abuse (five [11%], $P < .001$). Only 2/47 (4%) of parents whose children had not received examinations were concerned about infection.

Those parents who said they have had life experiences that made the examinations of their children difficult for them had a 2.76-fold increased odds of concern for injuries although this result was not statistically significant (OR = 3.8, 95% Cl: [0.76, 18.5], $P = .103$). Adjusting for a known offender increased the odds of concern by 4.00-fold (OR = 5.0, 95% Cl: [1.62, 21.6], $P = .029$), adjusting for parents' history of difficult life experiences. Seven of ten parents of examined children who reported having had life experiences that made the examinations difficult for them had been concerned about physical signs of penetration and physical evidence to legally prove sexual abuse/rape.